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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 07/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH ROWA	4412 SOUTH MAIN ST SALISBURY, NC 28147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329 SS=G	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, physician, pharmacy, and staff interviews, the facility failed to ensure a resident was monitored for excessive sedation from medication and increased sedation was reported to the physician. They also failed to ensure the resident was free from unnecessary drugs by administering a medication beyond the end date of the medication for 1 of 4 sampled	F 329	**The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies.** To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 329 Unnecessary Drugs Corrective Action: Resident # 2 is no longer in the facility. Medication Error Reports were completed on the two doses Benadryl given 6/18 and 6/19. The Nurses counseled concerning transcription of medication orders for specific number of days.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 7/29/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 329	Continued From page 1 residents receiving medications with interactive sedating side effects (resident #2). Findings include: Resident #2 was admitted to the facility 2/4/2013 with multiple diagnoses including acute bronchitis, asthma, congestive heart failure, osteoarthritis, hypertension, morbid obesity, diabetes mellitus II, and chronic pain. Review of the Medicare 5 day Minimum Data Set (MDS) dated 6/21/2013 noted that Resident #2 was cognitively intact, felt tired or had little energy over 2-6 of the last 7 days, and needed extensive assistance for activities of daily living. The MDS also indicated that Resident #2 had impairment of range of motion on one side of the upper extremities with occasional pain at level 8 that limited day to day activities. Scheduled and PRN (as needed) pain medications were given and antidepressants were given 7 out of 7 days of the review. Review of physician's orders found the following orders: 2/4/2013 Primidone 50 mg (milligrams) tab take 6 tabs po (by mouth) q (every) hs (bedtime). Neurontin 600 mg tab po bid (twice a day), Neurontin 100 mg capsule po qhs, Lortab 7.5/500 mg tab po tid (three times a day), no more that 3000mg acetaminophen q day from all sources Lortab 7.5/500 mg tab po q 4 hours for breakthrough pain no more that 3000 mg acetaminophen q day from all sources. Flexeril 10 mg po q 8 hours PRN muscle pain, 2/11/2013 Cymbalta 60 mg cap po qd 3/26/2013 Duragesic 50 mcg (micrograms)/hr	F 329	Identification of other residents who may be involved with this practice: All residents on pain management using narcotics or medication with interactive sedating side effects have the potential to be affected. An audit was completed on July 15th to July 26, 2013 by Renee Moore, CDONA on all residents receiving pain management or medication with interactive sedating side effects. The Nurses Notes were reviewed for the last month for evidence of lethargy, change in mental status or additional side effects associated with medication. Ensuring the MD was notified of residents with any change of condition. The audits showed that one resident had a sedation reaction to pain medications. MD is aware and new MD orders received to stop most of her medications and only use prn. All new MD orders for the last three weeks were	

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F 329	Continued From page 2 patch; apply 1 patch q 72 hours (every 3 days) rotate site Generic: Fentanyl 5/21/2013 Increase Primidone to 250 mg tabs q am and 250 mg tabs q pm and 6 50 mg tab qhs. 6/5/2013 at 9:00 pm Benadryl 25 mg po x 1 dose for itching or allergic reaction 6/7/2013 Benadryl 25 mg po q 6 hrs PRN itching x 7 days 6/13/2013 Increase duragesic patch to 75 mcg/hr change patch q 72 hours DC (discontinue) Lortab, DC current Neurontin orders. Neurontin 600 mg po tid MSIR (morphine sulfate instant release) 15 mg po q 4 hours PRN pain The 2013 Lippincott's Nursing Drug Guide read under drug to drug interactions of Primidone: increased CNS (central nervous system) effects. One of the CNS effects listed for Morphine was sedation, for Neurontin was somnolence (near sleep like state), for Fentanyl potentiation (enhancement of one agent by another so that the combined effect is greater than the sum of the effects of each one alone) of effects when given with other CNS acting drugs, for Flexeril additive CNS effects with barbiturates and other CNS depressants, for Cymbalta an adverse effect was somnolence, and for Benadryl increased sedation with other CNS depressants. A review of the June 1-June 30 2013 Medication Administration Record (MAR) found the following medication administrations: From 6/1-6/12/2013 Neurontin 600 mg was given at 6:30 am, 2:00 pm, and 100 mg at 8:00 pm, Cymbalta 60 mg was given at 8:00 am, Primidone 100 mg was given at 8:00 am, 2:00 pm, and 300	F 329	reviewed for medications ordered for a specific time period on July 5th by Renee Moore, CDONA with the help of the Supervisors and staff nurses. These orders were checked against the MAR to ensure stop dates were clearly indicated and the resident did not receive any medication post stop date. No issues were identified. In an effort to maintain a satisfactory pain management for the resident without adverse reactions. Systemic Changes: All Nurses and CNAs (full and part time) were in serviced on July 5th thru July 26th by Renee Moore, CDONA with monthly in services to continue until all staff are in serviced and understand the need for	

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F 329	Continued From page 3 mg at 8:00 pm, Benadryl 25 mg was given on 6/5 at 8:00 pm, 6/6 at 5:00 pm (? Time is not clear), 6/7 at 8:00 am, 6/8 at 1:45 pm, 6/9 at 3 pm, 6/10 at 4:30 pm, 6/11 at 7:40 am and 5:25 pm. (The Benadryl was given on 6/6 after order on 6/5 for a one time dose) Flexeril 10 mg on 6/4 at 12:00 ? (writing not clear) Fentanyl patch 50 mcg/hr was placed at 8:00 am on 6/3, 6/6, 6/9, and 6/12. On 6/13-6/23/2013 the medications were given as shown below: 6/13/13 6:00 am Neurontin 600 mg 8:00 am Primidone 100 mg, Cymbalta 60 mg po, Fentanyl 50 mcg/hr patch in place, 9:00 am Benadryl 25 mg, 11:30 am last dose of Lortab 7.5/500 mg, 2:00 pm Primidone 100 mg, Neurontin 600 mg, 8:00 pm Primidone 300 mg, Neurontin 600 mg, 6/14/13 at 8:00 am MSIR 15 mg, Primidone 100 mg, Neurontin 600 mg, and Cymbalta 60 mg, Fentanyl 50 mcg/hr patch in place. 2:00 pm Primidone 100 mg 600mg Neurontin, 8:00 pm Primidone 300 mg, Neurontin 600 mg 6/15/13 at 8:00 am she had a new Fentanyl patch at 75mcg/hr placed, Neurontin 600 mg, Primidone 100 mg, Cymbalta 60 mg 2:00 pm Primidone 100 mg and Neurontin 600 mg 8:00 pm Primidone 300 mg, Neurontin 600 mg On 6/16/13 at 12:00 am MSIR 15 mg At 8:00 am Primidone 100 mg, Neurontin 600 mg, Cymbalta 60 mg, Fentanyl patch 75 mcg/hr in place 10:00 am MSIR 15 mg 2:00 pm Primidone 100 mg 600 mg Neurontin,	F 329	monitoring residents receiving sedative medications. The topic included Pain Management utilizing narcotics and medications with interactive side effects of sedation. Signs and symptoms to observe for as lethargy, sedation, change in mental status, constipation, respiratory depression (slowed rate of breathing, one of the more serious concerns), nausea/vomiting, dizziness, weakness, dry mouth, difficulty in urination, and sleepiness with prompt notification of the MD of any changes in condition. Interact II tools were reviewed with staff for prompt reporting of changes. CNAs reviewed the Stop and Watch Tool and Nurses reviewed the SBAR Tool for reporting changes to the MD. An additional inservice on Medication transcription on orders with specified dates for administration was completed by Renee Moore, CDONA on July 5th. Thru July 26th. This included how	

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F 329	Continued From page 4 8:00 pm Primidone 300 mg, Neurontin 600 mg On 6/17/13 at 8:00 am Primidone 100 mg, Neurontin 600 mg, Cymbalta 60 mg, Fentanyl patch 75 mcg/hr in place 2:00 pm Primidone 100 mg 600 mg Neurontin, 8:00 pm Primidone 300 mg, Neurontin 600 mg On 6/18/13 at 8:00 am Primidone 100 mg, Neurontin 600 mg, Cymbalta 60 mg, new Fentanyl patch 75 mcg/hr placed. 2:00 pm Primidone 100 mg 600 mg Neurontin 4:30 pm MSIR 15 mg 8:00 pm Primidone 300 mg, Neurontin 600 mg, Benadryl 25 mg (The order for x 7 days ended on 6/14/13) 8:30 pm MSIR 15 mg On 6/19/13 at 8:00 am Primidone 100 mg, Neurontin 600 mg, Cymbalta 60 mg, Fentanyl patch 75 mcg/hr in place. 10:00 am Benadryl 25 mg (The order for x 7 days ended on 6/14/13). 2:00 pm Primidone 100 mg 600 mg Neurontin, MSIR 15 mg 6:30 pm MSIR 15 mg 8:00 pm Primidone 300 mg, Neurontin 600 mg 9:00 pm Flexeril 10 mg 10:30 pm MSIR 15 mg On 6/20/13 at 8:00 am Primidone 100 mg, Neurontin 600 mg, Cymbalta 60 mg, Fentanyl patch 75 mcg/hr in place. 2:00 pm Primidone 100 mg 600 mg Neurontin, MSIR 15 mg 8:00 pm Primidone 300 mg, Neurontin 600 mg	F 329	to appropriately transcribe the order to the MAR with stop dates clearly indicated. Any in-house staff who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monday through Friday The Daily Clinical Meeting will review the nursing daily report, incident reports, new MD orders for any medication with a specified stop date, and any resident with a change of condition as lethargy or signs or symptoms of sedation. The Team will ensure that MD was notified of any signs and symptoms of sedation and appropriate action taken by reviewing documentation in the	

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F 329	Continued From page 5 9:30 pm Flexeril 10 mg On 6/21/13 at 8:00 am Primidone 100 mg, Neurontin 600 mg, Cymbalta 60 mg, new Fentanyl patch 75 mcg/hr placed. 2:00 pm Primidone 100 mg 600 mg Neurontin, 4:45 pm MSIR 15 mg 8:00 pm Primidone 300 mg, Neurontin 600 mg On 6/22/13 at 8:00 am received Primidone 100 mg, Neurontin 600 mg, Cymbalta 60 mg, Fentanyl patch 75 mcg/hr in place. 9:00 am MSIR 15 mg 2:00 pm 100 mg 600 mg Neurontin, 8:00 pm Primidone 300 mg, Neurontin 600 mg 9:45 pm Flexeril 10 mg On 6/23/13 at 8:00 am Primidone 100 mg, Neurontin 600 mg, Cymbalta 60 mg, Fentanyl patch 75 mcg/hr in place. At 2:00 pm Primidone 100 mg 600 mg Neurontin, MSIR 15 mg. Nursing notes in review noted on 6/19/2013 that Resident #2 was given Benadryl 5 mg for a complaint of itching. On 6/20/2013 at 11:27 am Resident #2 was hard to awaken that morning, but was verbally stimulated for a moment and able to take her medications. On 6/21/2013 a note at 7:20 am indicated Resident #2 was sleeping each time the nurse went to visit on 6/20/2013. The note also revealed that Resident #2 was arousabl when spoken to and hand placed on the resident's arm, but did not open eyes when answering. Resident #2 was asked several times to get out of bed, but remained lethargic and sleepy. On 6/22/2013 at 2:07 am a note documented that Resident #2 was	F 329	Nurses notes, new MD order, MD progress note, SBAR, or other consultant information in the medical record. The Unit Manager will review the MAR of any new orders to ensure stop date is clearly indicated. Any issues will be reported to the Administrator and the Medical Director for appropriate action. The Clinical Meeting includes DON, Unit Managers, Support Nurse, Rehab Director, MDS, HIM, Wound Nurse, Dietary and other clinical staff as needed. Each month the pharmacist consultant will review each resident's medication regime including the use of narcotics and medication with interactive sedating side effects. The pharmacist will make written recommendations to the facility and the physician for changes. The DON will be responsible to	

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F 329	Continued From page 6 alert and verbal, but remained in bed with eyes closed. On 6/22/2013 at 12:12 pm the note detailed that Resident #2 was very sleepy and slow to respond to verbal stimulation, able to take meds, but was barely awake. On 6/22/2013 at 10:24 pm Resident #2 noted to be very lethargic that shift. She did awaken for family visit and Flexeril was given. On 6/23/2013 at 2:33 pm the note indicated that Resident #2 was resting in bed with eyes closed and no complaints of pain. On 6/23/2013 6:34 pm Resident #2 was unable to be aroused, had thick frothy secretions coming out of mouth and nose, and was suctioned by the nurse at 5:56 pm for 60 ml (milliliters) returned. The physician was notified that Resident #2 had no gag reflex, no sternal arousal, and oxygen saturation was 64%. An order was received and 911 called to transport Resident #2 to the hospital. There was no indication in the notes that the physician had been notified of Resident #2 ' s lethargy prior to the call when she was non responsive. Record review found 2 24 hour Change of Condition Reports which were left for the physician to see on the next visit. The first report was dated 6/22/13 noted that Resident #2 was very lethargic, hard to wake on days and lethargic until family arrived on evenings. The second report dated 6/23/2013 indicated that Resident #2 was sent to the hospital at 6:23 pm 3 days post antibiotics. Hospital records were reviewed and noted that Resident #2 was admitted with a known overdose	F 329	ensure all recommendations are reviewed and appropriate response recorded. Monitoring: To ensure compliance the Supervisor/Unit Manager will conduct a review using the QA Survey Tool observing three residents receiving narcotic pain management or medication with interactive sedating side effects. Nurse notes will be checked for prior week and resident observed for any side effects or change in condition ensuring that any side effects along with lethargy or sedation will be documented and the physician notified. A review of three MARs will be conducted to ensure any medication with a stop date is clearly indicated and the medication was not given past the stop date. This will be done five times a week for four weeks then monthly for three months. Identified issues will be	

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F 329	Continued From page 7 that was accidental. The record identified that Resident #2 had a Fentanyl patch, was given 15 mg of Morphine, and was found unresponsive. Resident #2 was given 2 mg of Narcan (a medication to counter the effects of an opiate overdose) at the hospital and became more responsive. A hospital physician s note indicated that it appeared to be a case of opiate toxicity. The Discharge diagnosis was altered mental status secondary to pain medication overdose and urinary tract infection (UTI). Laboratory blood test results noted that Resident #2 was positive for opiates and barbiturates. Urine tests confirmed a UTI. In an interview on 7/3/2013 at 9:09 am NA (nursing assistant) #1, who regularly cared for Resident #2, stated that for 2-3 days prior to being sent to the hospital Resident #2 was hard to wake up. She indicated that she reported this to the nurse. At 9:25 am on 7/3/2013 the Nursing Supervisor who wrote the above note on 6/21/2013, stated that right before Resident #2 went to the hospital, the resident had a good day and did get up. The next day Resident #2 was very groggy and didn't want to get up. The nursing supervisor added that Resident #2 had a lot of days when she slept a lot and she knew over the weekend got a lot sleepier. (weekend of 6/21-6/23) On 7/03/2013 at 12:26 pm Nurse #1, who gave the last dose of MSIR on 6/23, stated in an interview that the family asked her throughout the day to give Resident #2 MSIR for pain. The nurse indicated that she told the family that as long as the resident was sleeping without signs or	F 329	reported immediately to DON or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator. Date of Compliance: July 29, 2013	

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F 329	Continued From page 8 symptoms of pain, she was not going to give the medication as it caused sedation. After a dressing change she indicated that Resident #2 was yelling and saying there was pain. At that time the nurse gave a PRN dose of the MSIR. She included that she assessed Resident #2 later on and had no concerns. (The MAR indicated the pain went from a level 8 to 3, but no time was noted). At 12:40 pm on 7/3/2013 Nurse #2 stated in a telephone interview that when she began her shift at 3:00 pm on 6/23/2013, Resident #2 was sleeping. She revealed that from the first time she cared for Resident #2, the resident was sleeping more. The nurse said usually if she had medications to give she would wake Resident #2, but didn't have any to give so did not wake the resident. She shared that the NA came to her because when she went to give care, she found Resident # 2 had secretions coming from the mouth. Nurse #2 went to the room cleaned the resident's mouth and checked the breathing and oxygen saturation. At that time Resident #2 was in a deep sleep with unlabored respirations and oxygen saturation of 92%. She stated that she was aware that Resident #2 had received pain medication around 2:00 pm. The NA gave care and went back to check on Resident #2. At that time the resident had more secretions and the NA notified the nurse. The nurse again suctioned the secretions, called her supervisor who put an oxygen mask on the resident and measured the oxygen saturation at 64%. At that time Nurse #2 called the physician and received an order to send Resident #2 to the hospital by 911. Nurse #2 added that she left a communication for the physician so he could assess Resident #2 and	F 329		

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F 329	Continued From page 9 review her medications after the day nurse told her the resident had been sleeping all day. She said she didn't feel the resident sleeping a lot was urgent or she would have called the physician. On 7/3/2013 at 2:18 pm the pharmacy that provided medications for Resident #2 was called. A pharmacist stated in an interview that he was aware of an interaction between Primidone and Morphine, but in his reference it was considered moderate. They notified the facility if the interaction was a level 1, but this was not so they assumed the staff would monitor the resident for over sedation. The Director of Nurses (DON) stated in an interview on 7/3/13 at 4:00 pm that Resident #2 started having more pain in the legs and shoulders. She indicated that the physician took the resident off Lortab and put added Morphine and the resident had a duragesic patch. Resident#2 started refusing to get out of bed about the time the lethargy increased. However, the DON said whenever she went to visit the resident would wake and talk to her. She added that the physician came to the facility on Tuesdays and his nurse practitioner came on Mondays and Thursdays. The DON checked the communication book to the physician and indicated there was a message dated 6/22/2013 that Resident #2 was very lethargic. That was on Saturday and the nurse practitioner would not see it until Monday. The DON also stated that Resident #2 went to the hospital on Sunday 6/23/2013 unresponsive. The only explanation for the staff not calling a physician to report Resident #2's lethargy was that on call physicians on the weekend wouldn't change orders or write new	F 329		

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F 329	Continued From page 10 orders. They said either wait until the regular physician could see the resident on Monday or send them to the hospital. The DON said they hesitated to do that as the state got on them for sending resident's to the hospital who could be treated in house. A telephone interview was conducted with Resident #2's physician on 7/3/2013 at 4:13 pm. He stated that he was very aware of the interaction between Primidone and Morphine and usually tried not to use that combination, but Resident #2 had such unrelieved pain. He had not received any reports of increased sedation and if he had known he would have changed her medications. He added that he did not write an order for monitoring for sedation as it was implied with narcotics. He expected the staff to monitor for increased sedation and to notify him.	F 329		